MONTANA MENTAL HEALTH SERVICES PLAN
Prior Authorization Review Procedures

ADULT INTENSIVE OUTPATIENT SERVICES

Intensive Outpatient Therapy Services represent community-based treatment, with the following Services and Procedure Codes:

H0046 HB – Individual or Family Therapy
H2014 – 1:1 Telephone or Face-to-Face DBT Coaching and Case Management
H2014 HQ – DBT Skills Group

Intensive Outpatient Therapy Services must be provided by individuals or agencies licensed by the State of Montana.

This level of treatment intervention includes a consideration of the person's safety and security needs, including the ability and likelihood of the person to benefit from intensive outpatient treatment.

Prior Authorization Review Procedure

1) The provider must verify the recipient's MHSP eligibility.

2) The provider is responsible for notifying AMDD Benefit Management Team by fax within 24 hours or within one (1) business day of the admission. Delay in contacting the Benefit Management Team beyond the 24 hours or one (1) business day may result in a technical denial of authorization.

3) The provider must submit an authorization request form that includes demographic and clinical information. This information must be sufficient for the reviewer to make a determination regarding medical necessity and must include:

Demographic Information:

- Recipient's MHSP number
- Recipient's name, date of birth, sex
- Provider name, provider number and date of admission

Clinical Information:

- DSM-IV diagnosis on Axis I through V
- Treatment history and concurrent services
- Current Medication
- Current psychological symptoms
- Initial treatment plan
- Crisis Plan

4) The Prior Authorization Request Form must be complete and legible.

Continued Stay/Treatment Review Procedure

Definition

A continued stay treatment review is a review of currently delivered treatment and patient status to determine current medical necessity for a continued level of care.

Reviews of requests for continued treatment authorization are based on updated treatment plans, progress notes and recommendations of the individual's treatment team based on the patient's ongoing need for this level of services. Continued treatment requests require prior authorization and must meet be medical necessary. The length of continued treatment services authorized will depend solely on the recipient's level of functioning and clinical presentation provided by the provider.

Procedure

1) The provider is responsible for contact AMDD Benefit Management Team by fax **at least** 24 hours or one (1) business day prior to the termination of the initial authorization.

2) The provider must submit the following information to complete a continued treatment review:

   - Continued Stay Authorization Request Form
   - Changes to current DSM-IV diagnosis on Axis I through V
   - Service utilization within the past 90 days
   - Current list of medications or rationale for medication changes, if applicable
   - Current psychological symptoms
   - Changes to the treatment or crisis plan
   - Brief summary of the client's progress

3) The Continued Stay Request Form must be complete and legible.

Notification and Appeal Procedure

1) Upon receipt of the above documentation, the AMDD Benefit Management Team will complete the review process within 48 hours or two (2) business days from receipt of the review request and clinical information provided the information is sufficient to make the determination of medically necessary. The length of services initially authorized will depend solely on the recipient's level of functioning and clinical presentation.

2) If medical necessity is met, the AMDD Benefit Management Team will authorize the treatment and notify the provider.

3) If medical necessity is not met then the case is denied for service not meeting the medically necessary definition. The AMDD Benefit Management Team will authorize the continued treatment and notify the provider of the denial and the rationale for denial.

4) Requests for prior authorization may be denied for a variety of reasons, including, but not limited to:
    a) When an individual qualifies for Medicaid;
    b) When traditional outpatient psychotherapy is likely to meet the individual's needs;
    c) When services were delivered following a review that did not meet medical necessity definition.

5) Participating providers may choose to have such denied claims reviewed by filing an informal reconsideration with the Benefit Management Team of AMDD. This can be done by mailing or faxing a letter to the Benefit Management Team requesting such a review and including copies of all applicable documentation.

   AMDD must receive a written request for review within 30 days after the date of a notice denying a claim. The request for reconsideration should be mailed to the following address:

   Benefit Management Team

   Addictive and Mental Disorders Division

   Department of Public Health and Human Services

   Post Office Box 202905

   Helena, MT 59620-2905

   The department will conduct an informal reconsideration and may grant full or partial reimbursement for services provided.

   All requests for informal reconsideration need to be as specific as possible in terms of identifying the individual for whom the disputed services were provided, the date and time that such services were provided, the actual provider of the disputed services, and the names of any individuals at AMDD with whom the provider had contact concerning services provided during the episode in question. All requests for informal reconsideration will be reviewed by the Benefit Management Team of AMDD and a written response will be sent to the provider or provider's representative as noted in the letter requesting the reconsideration. Once the review is completed, all decisions are final.